DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 — 0 2 0

2. STATE: Louisiana

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
March 8, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.40

7. FEDERAL BUDGET IMPACT:
a. FFY 2000 $[illegible] (664.30)
b. FFY 2001 $[illegible] (1362.41)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-C page 1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same (TN# 99-07)

10. SUBJECT OF AMENDMENT: Reduction in reimbursement to private nursing facilities and private ICF-MRs for hospital leave days by twenty-five percent (25%).

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: The Governor does not review state plan material.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
David Hood by Jack LaCour

13. TYPED NAME:
David W. Hood

14. TITLE:
Secretary

15. DATE SUBMITTED:
March 27, 2000

16. RETURN TO:
State of Louisiana
Department of Health & Hospitals
1201 Capitol Access Road
PO Box 91030
Baton Rouge, LA 70821-9030

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
March 27, 2000

18. DATE APPROVED:
June 6, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
March 8, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:
Calvin G. Cline

21. TYPED NAME:
Calvin G. Cline

22. TITLE:
Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS FOR PAYMENT FOR RESERVING BEDS DURING A RECIPIENT'S ABSENCE FROM AN INPATIENT FACILITY

CITATION
42 CFR
447.40

PAYMENT FOR RESERVATION OF BEDS

A temporary absence of a recipient from a facility (nursing facility or ICF/MR) shall not interrupt the monthly payment to the facility provided the facility keeps a bed available for the recipient subject to the limitations outlined in I and II below.

The period of absence is determined by counting as the first day of absence the day the recipient left the facility. Only a period of twenty-four (24) hours or more shall be considered an absence. Absences for twenty-three (23) hours or less on a consistent basis could jeopardize continued medical certification for the resident.

The Bureau of Health Services Financing, Health Standards Section, shall determine whether hospitalization is for an acute condition or if a recipient's plan of care provides for leaves of absence.

I. Hospital Leave Days

A. For residents of Nursing Facilities, the bed is reserved for up to seven (7) days per hospitalization for treatment of an acute condition. Hospital leave days are reimbursed at seventy five percent (75%) of the applicable nursing facility per diem rate.

B. For residents of ICF/MR facilities, the bed is reserved for up to seven (7) days per hospitalization for treatment of an acute condition. Hospital leave days are reimbursed at seventy five percent (75%) of the applicable ICF/MR per diem rate.

II. Other Leave Days

The bed may be reserved for up to the limitations specified below for leave(s) of absence other than hospitalization.

STATE Louisiana
DATE RECD 03-27-2000
DATE APPVD 06-06-2001
DATE EFF 03-08-2000
HCFA 179 LA-00-20

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A. The bed of a resident of a long term care facility other than an ICF/MR facility is reserved for up to fifteen (15) days per calendar year for leave(s) of absence such as a visit with